CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF DENTISTRY AND DENTAL HYGIENE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE:DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR DENTAL RESIDENT LIMITED LICENSURE
INSTRUCTION SHEET

What is Dental Resident Limited Licensure?

This application is for dentists who will be starting a residency program in Delaware. Under a Dental Resident Limited License, you are allowed to practice dentistry:

- ***only*** in the sponsoring hospital or institution named on the license
- ***only*** under the direction of a licensed dentist employed by the sponsoring hospital or institution.

Dental Resident Limited Licenses are valid for one year. If you do not complete your residency program in the year, you may apply to continue your limited licensure.

Requirements for *All* Applicants

As the applicant, it is ***your*** responsibility – *not the responsibility of the institution or residency program* – to arrange for the Board to receive the documents listed below.

☐ Submit completed, signed and notarized *Application for Dental Resident Limited Licensure*.

☐ Enclose the non-refundable processing fee by check or money order made payable to the "State of Delaware."

☐ Arrange for the Board office to receive an official transcript of your undergraduate education, sent *directly* from the college/university (not the residency program) to the Board office.

☐ Arrange for the Board office to receive an official transcript from your dental college or university, sent *directly* from the school to the Board office. The transcript must show your degree and date of graduation

- The dental college/university must be accredited by the Commission on Dental Accreditation of the American Dental Association (CODA).
- If a final transcript is not available by the program start date, submit a letter from your school's dean attesting to your good academic standing.

☐ Submit a copy of your letter of acceptance into a dental residency program from the sponsoring institution. The program must be a CODA-accredited general practice residency or a CODA-approved specialty residency.

☐ Enclose a copy of your current cardiopulmonary resuscitation (CPR) certification card.

☐ Arrange for the Board office to receive license verification letters from *each* jurisdiction (state, U.S. territory or District of Columbia) where you are now, or have ever been, licensed, sent *directly* from the jurisdiction to the Board office.

☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.

The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

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IDENTIFYING AND CONTACT INFORMATION

1. Name :_____ _____ _____ _____
   Last/Family Name | First | Middle | Maiden

2. Other Name(s) Used: _____ _____ _____ ☐ None

3. Have you ever sought or been granted a dental license under another name? Yes ☐ No ☐ If yes, enter name and state where you used the name: _____

4. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

5. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ **If yes, enter your SSN:**_____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

6. Mailing Address:_____

   _____ _____ _____
   City | State | Zip

7. Phone: _____ _____ Email: _____
   Daytime | Home

RESIDENCY PROGRAM

8. Enter the following information about your residency program: Start Date: _____

   Name of Sponsoring Institution: _____

   Mailing Address: _____

   _____ _____ _____
   City | State | Zip

   Submit a copy of your letter of acceptance into the dental internship program from your sponsoring institution. Also, enclose a copy of your current cardiopulmonary resuscitation (CPR) certification card.

EDUCATION

9. Enter the following information about your pre-professional education:

   University/College: _____ Major: _____

   City: _____ State: _____ Degree: _____

   Dates Attended: From: _____ To: _____ Graduation Date: _____
   month/day/year | month/day/year | month/day/year

   Arrange for the Board office to receive an official transcript of your undergraduate education, sent directly from the college/university (not the residency program) to the Board office.

10. Enter the following information about your Dental education:

    Dental School Name: _____

    City: _____ State: _____ Degree: _____

    Dates Attended: From: _____ To: _____ Graduation Date: _____
    month/day/year month/day/year month/day/year

    Arrange for the Board office to receive an official transcript, sent *directly* from your dental school (<u>not</u> the residency program) to the Board office. If a final transcript is not available by the program start date, submit a letter from your school's dean attesting to your good academic standing.

LICENSURE & PRACTICE HISTORY

11. Enter the following information about your National Board Examinations:

    Year Taken:_____ Part I Score:_____ Part II Score:_____

12. Have you ever been denied a license? Yes ☐ No ☐ If yes, enter: Year Denied: _____ State: _____
    Submit a letter explaining fully.

13. Are you (*or have you ever been*) licensed in any other jurisdiction? Yes ☐ No ☐ If yes, enter the following information about *each* license:

JURISDICTION	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE	STATUS (e.g.,active)

    Arrange for *each* jurisdiction listed to send a verification of licensure *directly* to the Board office.

DISCLOSURES

14. Have you engaged in the illegal use of controlled dangerous substances within that past two years? Yes ☐ No ☐ **If yes, continue to Question 15. If no, skip to Question 16.**

15. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not illegally using controlled substances? Yes ☐ No ☐ **If yes, submit a letter explaining fully.**

16. Have you ever been denied a DEA (Narcotic) registration number? Yes ☐ No ☐ Current DEA #_____
    If yes, submit a letter explaining fully.

17. Has your professional license ever been subjected to disciplinary action (including but not limited to consent agreements, fines, probation, suspension or revocation)? Yes ☐ No ☐ **If yes, submit a letter explaining fully. Include an official Board order or other documents.**

18. Has any malpractice action been brought against you in the past five years? Yes ☐ No ☐ **If yes, enclose a list on a separate sheet of paper. Include dates, disposition and amount of awards or settlements, if any.**

19. Are any disciplinary or ethical complaints currently pending against you? Yes ☐ No ☐ **If yes, submit a letter fully explaining. Include copies of all official documents or Board orders.**

20. Are you physically or mentally incapable of engaging in the practice of dentistry according to generally accepted standards? Yes ☐ No ☐ **If yes, continue with Question 21. If no, skip to the DUTY TO REPORT section.**

21. Do you agree to submit to an examination to determine such capability as the Board may deem necessary?
    Yes ☐ No ☐

Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.

DUTY TO REPORT

22. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to self report any of the following within 30 days:
    - Any arrest or the bringing of an indictment or information charging you with a crime substantially related to the practice of dentistry and dental hygiene as defined in Section 11.0 of the Board's Rules and Regulations.
    - Any conviction, including any verdict of guilty or plea of guilty or no contest, of any crime substantially related to the practice of dentistry and dental hygiene as defined in the Section 11.0 of the Board's Rules and Regulations.

    I certify that I have read and understand all provisions in the Delaware Dental Practice Act, including 24 *Del. C.* §1131 and the Rules and Regulations listed above, and that I understand my *duty to self report*. Yes ☐ No ☐

23. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

24. You have a ***mandatory*** duty to file a written report with the Division of Professional Regulation within 30 days if you reasonably believe that any other dental or dental hygiene practitioner ***or*** any other healthcare practitioner, including any person licensed to practice medicine in Delaware:
    - has engaged in or is engaging in conduct that would constitute grounds for disciplinary action
    - may be unable to practice with reasonable skill and safety to the public due to mental illness or mental incompetence, physical illness (including deterioration through the aging process or loss of motor skill), or excessive abuse of drugs (including alcohol)
    - is excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1131A and that I understand my *duty to report*. Yes ☐ No ☐

To ensure consideration of your license application, the Board office must receive all of these items:
- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-6 weeks to receive your license.

AFFIDAVIT

I hereby apply to be considered for licensing as a Dental Resident by the Board of Dentistry and Dental Hygiene under the standards, qualifications and procedures established under Title 24, Chapter 11, of the *Delaware Code*. I have read the State statute governing dental residents in Delaware. I have also received and read the Board's Rules and Regulations regarding the practice of Dentistry and Dental Hygiene in Delaware. I understand that the Board may require evidence additional to the material herein, including a written examination, and transcripts of academic training.

I hereby swear or affirm that the information contained in this application is correct and I understand that any intentionally fraudulent information will be reported to the Attorney General.

APPLICANT SIGNATURE: _____ Date: _____

County of_____State of _____

Sworn or affirmed before me a Notary Public this_____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires on_____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED FEE WILL BE REJECTED.

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See Title 28, CFR 16.34 for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. ***Personal checks are not accepted in any county.*** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a FD-258 fingerprint form available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.

2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and *certified* check or money order ***(personal checks are not accepted)*** for $65.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.

⇨ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.

Revised 9/2017

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AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Funeral
- ☐ Massage
- ☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- ☐ Nursing (RN, LPN, APRN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual

Print your current full name:

_____ _____ _____ _____
Last Name First Name Middle Initial Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

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